1998 Report on Collaboration and Innovation in Rural Health

Part II - Annual Report to the Legislature & Planned Future Actions

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RURAL HEALTH POLICY COUNCIL
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Dear Colleague:

On behalf of the Rural Health Policy Council (RHPC), I am pleased to provide you a copy of the Council's *1998 Report on Collaboration and Innovation in Rural Health: Part II – Annual Report to the Legislature & Planned Future Actions.*

This *Part II Report* continues the Policy Council's commitment to provide ongoing information to California's rural health field regarding its activities. It reports on planned future actions resulting from the Policy Council's Vision, Mission and Workplan, issued earlier this year in the *Part I Report*. (A copy of *Part I* can be obtained by calling the RHPC Office, or by accessing the RHPC website, indicated above.)

Also contained is this report is the Policy Council's first Annual Report to the Legislature. The Policy Council will report each year on progress made toward achieving measurable performance objectives in each area addressed by the Policy Council's workplan.

The Policy Council remains grateful for your participation with us as we work to address these important issues. Your input is critical to our progress, and we encourage you to continue your invaluable contribution to this effort.

Sincerely,

Stephen W. Mayberg, Ph.D., Chair
Rural Health Policy Council

California Rural Health Policy Council

1998 Report on Collaboration and Innovation in Rural Health

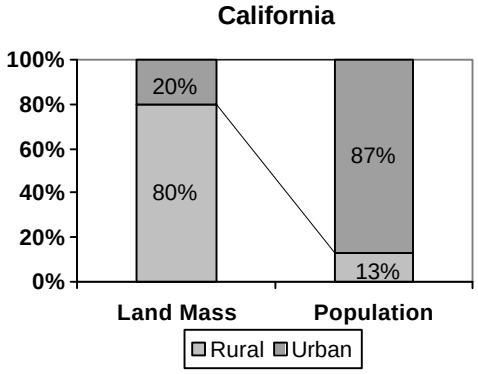
Part II – Annual Report to the Legislature & Planned Future Actions

Table of Contents

INTRODUCTION

- **Background**

Rural areas encompass 13% of California's population and 80% of its geography. All but three of California's counties have some defined rural area within their boundaries. Twenty-nine of the fifty-eight counties are considered entirely rural under the Rural Health Policy Council's definition. Some of these counties represent the most difficult areas in which to deliver services, being geographically remote, isolated during bad weather, and economically disadvantaged. Government spending, especially for health care, represents a significant portion of the economy in these areas.



Recognizing that rural areas of California were indeed different from urban metropolitan areas and required targeted attention, Assembly Bill 911 (Chapter 305/1995) was passed by the Legislature and signed by the Governor in September 1995. This landmark rural health legislation directed that a State Office of Rural Health or an "alternative organizational structure" be established as the focal point on rural health policy within State government. On March 8, 1996, Health and Welfare Agency Secretary Sandra R. Smoley, R.N., established the Rural Health Policy Council, consisting of the directors of the Department of Health Services, the Office of Statewide Health Planning and Development, the Department of Alcohol and Drug Programs, the Emergency Medical Services Authority, and the Department of Mental Health. The Policy Council then proceeded to carry out the various actions detailed in AB 911, in order to coordinate rural health policy in California.

Recently, Assembly Bill 2780 (Chapter 310/1998) added the Managed Risk Medical Insurance Board to the Policy Council. It also authorized a third year of Rural Health Policy Council grants, and added a required annual workplan and annual report to the Legislature. In other budget actions, the four loaned staff positions in the Rural Health Policy Council (RHPC) Office, assigned to manage the Policy Council's support functions to rural areas, were made permanent. These actions reflect the continuing commitment of both the Legislature and the Administration to addressing California's rural health issues.

- **Purpose of this Report**

Pursuant to Chapter 305/1995, on May 1, 1996, the Rural Health Policy Council submitted its *1996 Report on Rural Health* as a strategic plan to address rural health needs. The *1996 Report* documented many of the issues and needs of rural health care delivery in California, and listed many actions underway in the Policy Council, as well as various State agencies.

The Policy Council continues to report on progress to date and on planned activities for the future. In May 1998, it issued Part I of its *1998 Report on Collaboration and Innovation in Rural Health*, which covered activities undertaken from March 1996 through March 1998. A copy of the Part I Report can be obtained from the RHPC Office at (916) 654-2991, or may be viewed from the RHPC website (www.ruralhealth.ca.gov).

Part II reports on the major issue areas of the workplan; possible approaches for each of the areas are described. Pursuant to Chapter 310/1998, the Policy Council must adopt an annual workplan and report annually on progress towards meeting specific performance objectives that the Policy Council adopts for each workplan area. The first report is due to the Legislature by February 1, 1999, and is included in this volume.

It is the Policy Council's intent to make its reports as useful to the public as possible. Included at the end of this report is a form for your suggestions and comments, which you are encouraged to return by mail or FAX. This report and the comment form are also available via the RHPC website (www.ruralhealth.ca.gov).

EXECUTIVE SUMMARY

- **Process to Date**

  As reported in Part I of this report, the Rural Health Policy Council's efforts in working with rural health issues and communities in the first years could be characterized in three phases: developing structures for communication, developing issues, and addressing the identified issues. Each phase has had a corresponding activity – dialogue, analysis and action -- that has led to the next phase. The use of dialogue, objective analysis and collaborative efforts characterize the operating approach adopted by the Policy Council in its work.

  From this process emerged a clear vision and mission as well as a core set of issues that appeared central to the Policy Council's scope of responsibility. In December 1997, the Policy Council adopted a statement of its Vision, Mission and Major Issue Areas (see page 5). It also adopted a Project Workplan to guide the work of the Policy Council into the future, and to bring as many of these ideas to reality as possible.

- **Transforming Vision to Action**

  The Policy Council envisions changes in how State agencies will conduct business in rural areas. The Policy Council has directed the Interdepartmental Rural Health Coordinating Committee (IRHCC), composed of twenty managers from seven state agencies, to establish an agenda for specific areas of the Project Workplan each year, and to develop recommendations to address the issues raised. The IRHCC began this effort during 1998, addressing the Audit Consolidation process and the Resource Directory (see page 28 for details), as well as developing the content of this *1998 Report.*

  During this same time, new legislation (Chapter 310/1998) was enacted that requires an annual workplan and report to the Legislature. The Policy Council will use its existing Project Workplan as a starting point for the annual workplan.

- **Annual Workplan, Performance Objectives and Annual Report**

  Pursuant to recently enacted legislation, the RHPC Office is to develop an annual workplan that is to be adopted by the Policy Council. The workplan is to describe how the Policy Council will meet specific, measurable performance objectives. The workplan is to be designed to further the goals of the Policy Council to improve access to, and the quality of, health care in rural areas. The workplan must address how the Policy Council intends to address, at a minimum, all the following topics (which correspond directly to the major areas as originally adopted in the Policy Council's Project Workplan):

  (1) Increased standardization and consolidation of financial and statistical reporting, billing, audits, contracts, and budgets.
  (2) Network delivery and integrated delivery systems.
  (3) Streamlining the regulatory process.
  (4) Assessing the impact of managed care in rural communities.

(5) Reviewing and proposing changes necessary to improve current funding issues.
(6) Increasing the use of technology.
(7) Supporting innovative efforts to improve patient transportation.
(8) Providing strategic planning for local communities.
(9) Improving communication between the state and rural providers.
(10) Increasing workforce availability in rural areas.

The Policy Council is to provide an annual report to the chairs of the fiscal and policy committees of the Legislature on the outcomes achieved during the preceding twelve months and what changes it will incorporate into the workplan for the following year. The first report is due to the Legislature by February 1, 1999. In compliance with these requirements, the Policy Council has incorporated the requested report on performance objectives into a section beginning on page 24 of this report, entitled *Annual Report to the Legislature*.

- **Next Steps**

The Policy Council envisions ongoing work towards adopting approaches to each of these workplan areas. Each issue will be assigned to a department or group of departments, which will continue the process of research, analysis, and dialogue between the State staff and the affected local entities, with the expectation that improved systems and services in rural areas will result.

The workplan will be monitored by measuring progress in achieving results established by the adopted performance objectives. Progress towards implementing the action plans will be reviewed by the responsible RHPC departments, and discussed at least quarterly by the Policy Council.

The Policy Council will continue to hold quarterly public meetings in locations throughout California in order to provide ongoing opportunities for public comment on emerging issues and on the planned actions. By these means, the Policy Council will continue its strong commitment to improving the health care delivery system in rural areas.

Rural Health Policy Council
Vision, Mission, and Major Issue Areas

(Adopted December 1997)

VISION

Residents of rural communities in California will experience improved health status through planned improvements to their local delivery systems for health care and prevention services.

MISSION

The Rural Health Policy Council will advance this vision by ensuring that its State agencies continue to improve communication and cooperation with one another, working in a team approach with rural communities to address the health care issues they face.

Furthermore, the Rural Health Policy Council envisions an ideal rural health care delivery system of the future as:

- fully integrating locally defined health and prevention related services;
- maintaining broad community involvement, collaboration, and acceptance; and,
- using effective strategic local planning, that focuses on measurable outcomes that seek continuous improvement to the overall health status of the entire community.

The Rural Health Policy Council will support communities in designing, developing and achieving their goals by promoting responsive, supportive and timely actions by State agencies, the Legislature, counties, statewide organizations and private foundations. This support could take many forms, by:

- providing expertise, data and technical assistance to rural providers in planning, developing and implementing successful health care delivery systems;
- discussing and redrafting State regulations that may hinder rural providers from delivering the most efficient and appropriate services to their communities;
- streamlining State funding and administrative processes; and,
- working with other public and private funders to assure that resources are targeted in the most efficient and least duplicative ways, and that the gaps in services are filled to the greatest extent possible.

MAJOR ISSUE AREAS

- Standardization and Consolidation
- Network Development/Integrated Delivery Systems
- Regulations
- Managed Care
- Funding
- Technology
- Program-specific Reviews
- Outcome-based State Management
- Strategic Planning for Local Communities
- Transportation
- Communication
- Workforce Availability

ISSUES FOR POLICY CONSIDERATION

- **Overview**
  - The Rural Health Policy Council presents the background papers in this section in order to summarize the status of the issues as currently viewed by the many constituents of California's rural health field. Often these background papers present views stated by the rural health providers, and those views may or may not be shared by the Policy Council.
  - The Policy Council envisions ongoing efforts towards adopting approaches to each of these issues. It will assign each issue to a department or group of departments that will continue the process of research, analysis, and dialogue between the State staff and the affected local entities, with the expectation that improved systems and services in rural areas will result.
  - Many of the possible approaches involve seeking federal waivers or legislation, or setting up an exception process for providers in rural areas. The Policy Council recognizes that urban providers may then want some of these same exceptions extended to them as well.

- **Principles and Assumptions**
  - Members of both the Policy Council and the rural health community believe that the overarching goal of State and federal programs is to improve the health status of residents and to maintain access to health care services in California's rural areas.
  - State departments on the Policy Council believe that the people living and working in rural communities are in the best position to identify their needs and to work collaboratively with State programs to address those needs.
  - State departments on the Policy Council will consider pursuing federal waivers and/or state and federal legislative or regulatory changes, when necessary and appropriate.
  - State departments on the Policy Council will pursue changes to the administrative processes under their authority, when necessary and appropriate.
  - Reducing costs associated with state administrative requirements is desirable, so that the savings can be directed to services for residents in rural communities.
  - State departments on the Policy Council recognize the critical role played by rural health providers in providing access to health services for rural residents. Rural service delivery systems are strengthened when State programs recognize and plan specific provisions for "safety net" providers in rural areas, as was recently demonstrated in the implementation of California's Healthy Families program.

1 Standardization and Consolidation

Summary of the Issue

In order to maximize their funding opportunities, rural health providers must comply with administrative requirements from approximately one hundred different health programs that the State administers, monitors and audits, most often with separate policies, procedures and regulations. Many in the rural health field would like to see a consolidation of these programs, so that less funding is spent on administration and more funding is available for direct patient services.

Background/History

Historically, federal and State budgets appropriate funding for a wide variety of specific health-related programs. Some of the issues with the current system raised by the rural health providers involve how the awards are made, the high cost of administering the awards and the ability to meet actual rural needs with these funds, as follows:

- Typically, these programs arise from specific unmet needs identified in urban areas. These targeted funds may or may not be effective in rural areas. Even when appropriately targeted, the allocation of funding available to each provider is usually based on criteria relevant to urban areas. The impression among rural providers is that these allocation processes result in awards to rural areas that may not cover the costs of complying with the numerous administrative requirements associated with each funding source.

- The categorical funding streams lead to higher costs in administering the grants. Each funding source requires separate contracts, separate line item budgets, separate staffing by the recipient, separate statistical reporting, separate invoicing, separate financial accounting and reporting, separate program reviews for compliance, separate auditing, and lastly, a separate appeals process.

- Finally, the categorical process is perceived by many rural providers as limiting the ability of rural communities to use the funds where most needed or to respond quickly enough when local needs change.

Some efforts have been made to change current practice. A few years ago Molly Coye, M.D., as Director of Health Services, led efforts in this area. Legislative activity led to AB 1741 that allowed pilot counties to test consolidation of some of these programs in innovative ways. Also, the Department of Health Services continues to pilot a cost allocation system in Placer County, which should soon yield results. These past and current efforts should be reviewed for applicable lessons.

Desired Outcomes

- The RHPC is committed to encouraging State departments to standardize and consolidate requirements in the areas of statistical reporting, billing and financial reporting, audits, contracts, and budgets, both within and across departments, to the greatest degree possible.

- Many in the rural health community support efforts to move towards a simplified block grant approach for rural areas, with appropriate safeguards on allowable expenditures, but also with performance objectives tied to meaningful outcomes, such as improvements in health status indicators.

2 Network Development/Integrated Delivery Systems

Summary of the Issue

In order to maintain services and access in rural areas in an era of rapid change occurring in the health care market, rural health providers have expressed the need for financial and/or technical support from State departments for developing provider networks and integrating delivery systems in rural areas.

Background/History

Historically, the fee-for-service system created financial incentives that supported competition among providers for market share. With the advent of managed care systems, the environment has changed substantially, such that few financial payors, either public or private, continue to pay providers on a fee-for-service basis. More payors are shifting financial risk to the health care provider through a system of capitated monthly payments per patient. Medicaid reimbursement to clinics, based on actual costs incurred in providing care, is scheduled to phase-out over a five-year period.

These changes are requiring rural health providers to alter the way they do business. Providers recognize that it will be difficult for stand-alone providers to survive. Consequently, providers in many communities are in various stages of building relationships, networking and entering into formal partnerships. Successful efforts will reduce duplicative services (direct patient care, ancillary and administrative) and have the potential to add new patient services. Access to and availability of health care services would be improved.

Some limitations may exist when applying a network model to the extremely rural, (so-called "frontier") areas of California. Issues of distance and demographics impact most keenly in these areas. Practitioners in the most common medical specialty areas of need, e.g., ENT, dermatology and orthopedics, are not available in these counties or are located beyond a reasonable travel distance. Moreover, the demographic incidence of needing such specialists in these regions is typically not frequent enough to financially support having specialists in a network. Nonetheless, networks may be appropriate in the less remote rural areas.

Desired Outcomes

- The rural health community would like recognition that the rural health providers are an important part of every rural community's economy, both in providing a strong employment base and in attracting new businesses and economic development to that community.
- The rural health community would like assurance that the value of services and access is recognized and supported by the State.
- The rural health community would like the State departments to facilitate support and assistance to efforts similar to some currently being developed, such as:
  - California State Rural Health Association's feasibility study of financing mechanisms, including a statewide rural Health Maintenance Organization, and
  - Pilot efforts, such as the James Irvine Foundation's three-year initiative, Developing Rural Integrated Systems (DRIS).
- The RHPC intends that State departments will support efforts that continue to build upon and improve the provision of health care services and access in rural areas.

3 Regulations

Summary of the Issue

Rural health providers perceive that State regulations are often designed for urban-based health providers. Moreover, their perception is that State interpretation and application of these regulations are sometimes inconsistent.

Background/History

Providers report many challenges in complying with State regulations. Most often, the need to perform multiple roles and lack of specific training may bear on the ability to "get it all done."

- Rural health providers often have multiple responsibilities in contrast to an urban setting, where one or even many individuals are charged with a single responsibility. For example, a rural hospital administrator may be responsible for a general acute care hospital, emergency room, radiology, pharmacy, laboratory, emergency medical transportation, skilled nursing facility, primary care clinic, home health services, and recruitment of clinical providers. At the same time, this person might also be the chief financial officer while the hospital recruits for a replacement.

- It is not unusual for the chief administrative person of a hospital, clinic or other health provider to have spent an entire career in one organization. Such individuals may not have the benefit of a specialized education or internship in the areas for which they find themselves responsible.

The perceived need among rural providers is to have a streamlined regulatory system that (1) reflects rural circumstances and (2) provides technical assistance and training to rural administrators. Rural providers believe that this could be accomplished without compromising quality or causing conflicts of interest.

Another issue is the providers' perception that regulations are not always consistently interpreted. The perception is that a change in State reviewers from one year to the next sometimes appears to change how the regulations are interpreted. In a similar issue, rural providers also express their need to have State reviewers with more knowledge of rural health delivery systems.

In summary, it can be said that the current regulatory and financial systems for publicly funded health care in California require a high level of accountability. This level may be difficult to achieve in rural areas because of resource and training issues.

Desired Outcomes

- The rural health community wants regulations that reflect the realities of rural health care settings, and are flexible and consistently interpreted by State staff knowledgeable about rural health delivery issues.
- The RHPC continues to encourage State departments to provide assistance to rural providers in complying with meeting regulations, standards and policies.
- The RHPC continues to encourage State departments to develop appropriate and flexible interpretations that take into consideration the unique circumstances specific to rural areas, without compromising issues of health, safety and quality care.

4 Managed Care

Summary of the Issue

The ability of rural health providers to compete successfully in a managed care environment is of concern to many rural providers.

Background/History

Currently, different forms of managed care are under rapid development in California. All of these forms were developed from urban models, in areas with the largest populations of beneficiaries and the highest number of health care providers located in very competitive markets. Whether these models are appropriate to rural settings has been questioned. Moreover, rural providers are concerned about their continued ability to operate in regions into which established managed care systems are moving from their urban bases.

Of special concern to rural providers is the shift to managed care strategies for populations that are traditionally served by these providers. For instance, the Medi-Cal program has four different types of managed care programs. These were implemented on a countywide basis, including counties that have vast rural areas, often served by a few rural health providers, as follows:

1. County Organized Health Systems (4 counties with rural areas):
   San Mateo, Santa Barbara, Santa Cruz, Solano
2. Geographic Managed Care (2 counties with rural areas):
   Sacramento and San Diego
3. Two Plan Model (10 counties with rural areas):
   Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Joaquin, Santa Clara, Stanislaus, Tulare
4. Fee-for-Service Managed Care (2 counties with rural areas):
   Placer and Sonoma

In addition, California's Healthy Families Program is a statewide program covering all 58 counties, 55 of which have defined rural areas. This program began enrolling beneficiaries on July 1, 1998.

Desired Outcomes

- Rural health providers would encourage State departments responsible for the managed care programs to consider fully the financial and administrative limitations of rural health providers, as well as the impacts of managed care programs on them.
- The RHPC supports State departments in their efforts to increase health services and access for citizens in rural areas.

5 Funding

Summary of the Issue

Rural health providers have limited resources and must deal with problems associated with uncompensated care and the lack of economies of scale. They often express the need for additional funding to meet the needs of their communities.

Background/History

Historically, both the federal and State government have provided funding to health providers (hospitals, clinics, county health departments, etc.), with requirements that prescribed how the funds were to be used. Most often, these requirements were formulated based upon demographic trends in urban areas, which may or may not have reflected the most pressing needs in rural areas. While rural health providers have also been recipients of these funds, the amount of their awards is often based on population formulas, which result in amounts in small counties that are not large enough to be used effectively. Also, rural providers cannot benefit from economies of scale.

In addition, as described in Issue 1 "Standards and Consolidation", these funds are categorized so that each funding stream often requires a separate contract, line item budget, data reporting requirements, auditing, and a fixed percentage of time devoted by identified members of the provider's staff. Providers report their impression that these requirements decrease the available funds for actual services.

Infrastructure funding is also undergoing changes. State and federal agencies have historically provided little in ongoing funding for equipment and capital funding. These agencies have funded services, and consider infrastructure a local responsibility. With the changing environment of managed care and reimbursement practices, providers feel that it will be increasingly difficult to generate sufficient funds through their operations to meet their capital needs.

Providers also speak of moving to performance-based outcome measures, rather than relying on the budget-based management system now in place. This concept is discussed further in Issue 8, "Outcome-Based State Management."

Desired Outcomes

- The RHPC supports efforts to identify funding sources for capital needs in rural areas, such as the recent budget augmentations for the Rural Demonstration Projects under the Healthy Families Program and $3 million for capital and equipment grants.
- The RHPC encourages efforts to simplify, streamline and expedite the application processes for various funding sources to the greatest extent possible.
- Rural health providers would support legislation to reduce categorical funding streams whenever possible, and to coordinate funding efforts that target rural communities.
- The RHPC anticipates that State departments will make efforts to coordinate funding activities in rural areas to avoid duplication and to maximize the benefit of their funding efforts.
- The RHPC anticipates State departments will coordinate funding activities with other funders, such as private foundations.

6 Technology

Summary of the Issue

The revolution in electronic technology has created opportunities for telehealth and telemedicine (TH/TM) applications for rural health care providers.

Background/History

A core reality of rural and frontier areas has been isolation, whether it be geographically based or a result of seasonal weather conditions, mud slides, washed out roads and bridges, fires or other natural disasters.

Rural health care professionals are also isolated in many ways. Many express that they find themselves isolated from their colleagues, on-call twenty-four hours a day, unable to participate in many continuing medical education classes (which are usually held in urban areas), and unable to refer their patients to local specialists because so few of these practice in rural areas.

Clinical charts, diagnostic test results, administrative records, financial reports, data reports, billing, purchasing and accounts receivable may be done manually in rural clinics, without the benefit of any computerization. Meanwhile, advances in the ability to send high quality images between physicians or to hold two-way video consultations are resulting in changes to health care delivery not even considered a few years ago.

Currently, many developments are taking place in the TH/TM field:

- Utility companies are actively expanding the availability of T1 and Integrated Services Digital Network (ISDN) fiber optic telephone lines that will provide the core infrastructure to make high-speed transmissions and connection to the Internet possible. The federal government has made $400 million available to health providers, libraries and schools in rural areas to offset the telephone line charges incurred in connecting to the Internet.

- The Sierra Health Foundation is providing three-year funding that supports the California TeleHealth/TeleMedicine Resource Center, based at the California Healthcare Association offices in Sacramento. The Resource Center recently awarded $225,000 for five TH/TM grants in Bieber, Dorris, Downieville, Susanville and Sonora.

- Recently passed State legislation (Chapter 310/1998) further allows providers to bill Medi-Cal for patient care, when using store-forward and other telemedicine technologies that meet a specified standard.

- The Managed Risk Medical Insurance Board (MRMIB) has awarded Blue Cross of California a $1.85 million grant to address the needs of subscribers in the Healthy Families Program in rural areas through the use of telemedicine. Blue Cross will be partnering with the University of California, Davis, and Cedars-Sinai Health Systems in expanding existing sites and establishing 20 additional sites in rural areas across the State.

Many State departments, e.g., the Departments of Corrections, Developmental Services, Aging, Health Services, and Education, and the University of California, have either

implemented TH/TM systems or are in the process of developing them individually. Collaborative efforts to build these systems would be in the best interests of all parties.

Desired Outcomes

- The RHPC anticipates that its member departments will assist, whenever possible, in identifying funding sources for rural health providers that will enable them to purchase, install and develop operational TH/TM systems.
- The rural health community urges State departments to develop new and/or modify existing regulations that will allow providers of telemedicine to be reimbursed for patient care.
- Rural health providers support efforts among State to assume a leadership role in the development, application and expansion of TH/TM activities.
- Rural health providers support the establishment of a “focal point” within State government that can provide technical assistance to rural health providers, and will work in collaboration with the California TeleHealth/TeleMedicine Resource Center or other agencies developing this capacity in rural areas.

Summary of the Issue

Health care delivery in rural areas may benefit from a review of certain programs. Rural counties believe that State departments could recognize the administrative and staffing limitations and lack of economies of scale present in small counties, and provide flexibility to these areas, without compromising the goals of individual programs.

Background/History

Small counties report difficulties in complying with the State requirements of specific programs. For instance, they raise concerns about the program staffing requirements that appear to be designed for large counties with sufficient depths of staff to meet those requirements.

Desired Outcomes

- The rural health community urges State staff to work together with rural areas on the limitations of small counties in complying with requirements designed for larger counties with greater resources, and to be willing to provide flexibility to small counties.

8 Outcome-Based State Management

Summary of the Issue

Many in the rural health community would prefer State departments to focus more on the positive and lasting impact that their programs and funding have on rural residents and communities, and less on administrative, budget and process-related activities as indicators of program success.

Background/History

State departments administer approximately one hundred different health-related programs, each with its own requirements for contracting, invoicing and auditing. Most of these programs tie performance to output indicators, such as the number of patient visits, client encounters, vouchers or caseload counts. Often, such data is used to calculate future funding allocations for programs. If entities do not report this data, their financial situation suffers.

Rural providers report the lack of performance indicators that go beyond the output statistics and that would, instead, measure impact on the health status of the person served and/or the community as a whole. However, these indicators are not without problems where populations and incidences are too small to be statistically reliable. This problem exists in the smallest counties for some of the data elements currently reported for Healthy People 2000. In addition, equity issues invariably arise concerning the fairness of what is to be measured, as well as the accuracy and timeliness of the data itself. The difficulty of achieving consensus on what is to be measured and the increased costs associated with data collection cannot be overlooked.

As an alternative, the rural health providers may consider a system of performance indicators that target productivity and quality of care. Program review efforts that focused on cost-per-visit data have been used successfully in the past, leading to improvements in the provider's fiscal self-sufficiency and cost effectiveness.

Desired Outcomes

- The RHPC supports the use of administrative processes and data that will contribute to better service delivery, and ultimately to the improved health status of California rural residents, while maintaining fiscal and other accountability standards.

9 Transportation

Summary of the Issue

Rural residents needing medical care are frequently unable to access care because they have no transportation to the nearest medical facility. In extreme cases, they sometimes resort to calling an ambulance, which makes that the Advanced Life Support/Basics Life Support (ALS/BLS) unit unavailable for true emergencies and is the highest cost method of transportation within our health care system.

Background/History

Rural areas throughout California are challenged daily by the lack of non-emergency transportation for health care. This issue is mentioned repeatedly by rural residents and by the health care providers upon whom they rely. In many communities, persons needing non-emergency clinical services will drive if they have a car, get a ride from a neighbor, hitchhike, walk, call the sheriff or police, ask for a home visit, or in extreme circumstances, call an ambulance.

However, part of the problem may be resolved with further research into the issues and by creative collaboration methods. For example, the Trinity County Health Care Task Force looked at barriers that they thought prevented them from sharing transportation resources across departments. Finding these to be fewer than they had thought, the Task Force developed a Joint Powers Agreement with departments that each provide some type of transportation. This collaborative effort will allow persons needing transportation to access transportation from any of the participating departments.

This example from Trinity County provides insight into the rural transportation issue in general; that is, the lack of transportation resources is not limited to the health care sector but extends across most rural service sectors as well. Perhaps the focus should not be to solve *health care* transportation shortages, but to look at a broad range of rural service systems and to explore linkages to CALTRANS resources for planning local transportation systems. For instance, using provisions of Section 5311 of the Federal Transit Act, Fresno County has developed a Rural Transit Agency with nineteen subsystems, running a combination of demand responsive and scheduled fixed routes.

Desired Outcomes

- The RHPC is committed to encouraging State departments to recognize and understand the transportation issues impacting residents of rural areas of California, and to facilitate adoption of innovative efforts to improve patient transportation in rural areas.

10 Strategic Planning for Local Communities

Summary of the Issue

Rural communities recognize the value of strategic planning for their communities, but often do not have the resources or expertise locally to conduct it.

Background/History

For many years, health providers in rural communities have described functioning mostly in a reactive mode. Often these same communities do not have the resources or expertise necessary to formulate a plan that moves the community into a pro-active mode, where it can anticipate and plan in advance for its projected needs.

Rural communities have expressed interest in developing and implementing strategic plans, but are often unable to realize their goal of producing tangible, usable planning documents. In recent efforts, private foundations have established long-term funding support for rural efforts to integrate local health care delivery systems. For example, the James Irvine Foundation is providing three-year funding to five DRIS communities (Imperial, Ridgecrest, Lompoc, Humboldt and Siskiyou) to support a community-based planning process among provider networks. More public-private collaborations of this kind may be a possibility worth exploring.

Similar to findings in Issue 8, "Outcome-Based State Management", the rural health community has expressed the need for assistance in developing reliable data and the systems to support ongoing data collection. Such data is fundamental to successful planning efforts, and efforts to improve the rural communities' access to more user-friendly data would be welcome.

Desired Outcomes

- The RHPC acknowledges the value of having rural communities participate in a strategic planning process and produce written strategic plans.
- The rural health community expresses the need for either State financial support or direct technical assistance for the development of strategic plans in rural communities or regions.
- The RHPC encourages State departments to explore development of a "boilerplate" strategic plan that could be used by rural communities in guiding their efforts and could serve to "standardize" the final product from one rural community to another.

11 Communication

Summary of the Issue

The lack of effective cross-department communication and coordination on rural health activities among federal, State and local departments adversely impacts rural communities.

Background/History

State departments have historically operated in relative independence from one another. The Rural Health Policy Council and its Interdepartmental Rural Health Coordinating Committee were established in order to create a forum that promotes communication, coordination and collaboration, and reduced fragmentation.

In addition, rural communities report frustration when accessing State agencies. The Policy Council has provided a focal point of contact to ensure that rural officials and providers find such access and are responded to promptly.

Desired Outcomes

- The RHPC anticipates that State departments will continue to work together in a collaborative, team approach.
- The rural health community urges State departments to include rural providers and health care associations, to the greatest extent possible, in discussions prior to decisions being made.

12 Workforce Availability

Summary of the Issue

Rural health providers face difficulties in recruiting clinical providers and experienced, knowledgeable administrative staff. Even if providers are successful in recruiting such individuals, the providers then face the challenge of retaining them.

Background/History

Providers of health care in rural areas report the difficulties with recruitment and retention of experienced, knowledgeable and competent staff. They must compete against their non-rural counterparts who generally offer higher compensation, better benefit packages, shopping centers, cultural activities and educational opportunities.

Professional isolation is also a continuous factor. Although not a total solution, the development of telehealth and telemedicine in rural areas is hoped by many to reduce isolation and enable practitioners to communicate and consult with their colleagues in other locations.

To assist providers with recruitment of primary care physicians and mid-level practitioners, State agencies fund (1) programs that certify preparation of practitioners for rural areas, and (2) programs that reimburse the training costs of the practitioners. For example, the Office of Statewide Health Planning and Development provides financial incentives through the Song-Brown Program for family practice physicians in residency, as well as student loan repayment programs through the National Health Service Corps and the State Loan Repayment Program. The California Health Manpower Policy Commission identifies shortage areas in the State for physicians and mid-level medical practitioners.

Moreover, rural health providers' recruitment and retention challenges are not only with medical practitioners. Many providers experience great difficulty in recruiting administrators and chief executive officers, financial officers, maintenance personnel, billing clerks, mental health professionals (e.g., psychiatrists, psychologists, and licensed clinical social workers), dental professionals, physical/occupational/recreational/speech therapists, pharmacists, and laboratory or radiology technicians.

In order to assist these rural providers in their recruitment efforts, the RHPC Office designed and operates a "Rural Jobs Available" service, connected to 46 other states, that lists all employment opportunities with rural health providers.

Desired Outcomes

- The RHPC encourages State departments to continue efforts that improve the recruitment and retention of health professionals in rural areas of California.
- The RHPC supports regulation, reimbursement and funding strategies that encourage the development and application of technologies, e.g., telehealth and telemedicine, aimed at solving workforce and service availability issues in rural areas.
- The RHPC recognizes that non-clinical individuals may be just as critical to the operations of the health provider as those providing direct patient care.

- The rural health community urges legislation that recognizes the needs and constraints of rural health providers, by considering flexibility of staffing requirements and scope of practice requirements.
- The rural health community encourages community colleges to offer courses through multiple means, e.g., on campus, distance learning, satellite or down-link, in career areas needed by rural health providers.

ANNUAL REPORT TO THE LEGISLATURE

For February 1, 1999

ANNUAL REPORT TO THE LEGISLATURE

- This section of the report is respectfully submitted pursuant to Health and Safety Code Section 1179.5.
- This is the first report submitted under the new legislation requiring an annual report to the Legislature. As indicated in the "Planned Actions" in the following table, the Policy Council will be working on adopting new workplan approaches, as outlined in the preceding background papers, and the performance objectives tied to the adopted approaches during the next twelve months.
- This annual report also includes summary information on the Policy Council's competitive grant program. Also included is a summary of the RHPC Office objectives.

Rural Health Policy Council

Annual Report on Performance Objectives

(Report Year Ending September 30, 1998)

Performance Objectives	Outcomes Achieved	Planned Actions for Next 12 Months[1]
1 Standardization and Consolidation In order to maximize their funding opportunities, rural health providers must comply with administrative requirements from approximately one hundred different health programs that the State administers, monitors and audits, most often with separate policies, procedures and regulations. Many in the rural health field would like to see a consolidation of these programs, so that less funding is spent on administration and more funding is available for direct patient services.		
1. Review and report to the Policy Council on current and potential efforts towards audit consolidation.	1. Adopted the findings of the report to continue current efforts and to find further coordination opportunities, additional audit training, and etc.	1. Audit portion completed; report received. Actions undertaken to resolve rural hospital and clinic audit concerns are ongoing, and can be revisited by RHPC when appropriate.
		2. Adopt a recommended approach(es) and develop related performance objectives by March 31, 1999.
2 Network Development/Integrated Delivery Systems In order to maintain services and access in rural areas in an era of rapid change occurring in the health care market, rural health providers have expressed the need for financial and/or technical support from State departments for developing provider networks and integrating delivery systems in rural areas.		
		Adopt a recommended approach(es) and develop related performance objectives by March 31, 1999.

[1] Subject to review and adoption by the incoming RHPC.

Performance Objectives	Outcomes Achieved	Planned Actions for Next 12 Months[1]
3 Regulation Rural health providers perceive that State regulations are often designed for urban-based health providers. Moreover, their perception is that State interpretation and application of these regulations are sometimes inconsistent.		
		Adopt a recommended approach(es) and develop related performance objectives by March 31, 1999.
4 Managed Care The ability of rural health providers to compete successfully in a managed care environment is of concern to many rural providers.		
		Adopt a recommended approach(es) and develop related performance objectives by March 31, 1999.
5 Funding Rural health providers have limited resources and must deal with problems associated with uncompensated care and the lack of economies of scale. They often express the need for additional funding to meet the needs of their communities.		
		Adopt a recommended approach(es) and develop related performance objectives by March 31, 1999.
6 Technology The revolution in electronic technology has created opportunities for telehealth and telemedicine (TH/TM) applications for rural health care providers.		
		Adopt a recommended approach(es) and develop related performance objectives by March 31, 1999.

Performance Objectives	Outcomes Achieved	Planned Actions for Next 12 Months[1]
7 Program-specific Reviews Health care delivery in rural areas may benefit from a review of certain programs. Rural counties believe that State departments could recognize the administrative and staffing limitations and lack of economies of scale present in small counties, and provide flexibility to these areas, without compromising the goals of individual programs.		
		Adopt a recommended approach(es) and develop related performance objectives by June 30, 1999.
8 Outcome-Based State Management Many in the rural health community would prefer State departments to focus more on the positive and lasting impact that their programs and funding have on rural residents and communities, and less on administrative, budget and process-related activities as indicators of program success.		
		Adopt a recommended approach(es) and develop related performance objectives by June 30, 1999.
9 Transportation Rural residents needing medical care are frequently unable to access care because they have no transportation to the nearest medical facility. In extreme cases, they sometimes resort to calling an ambulance, which makes that Advanced Life Support/Basic Life Support (ALS/BLS)unit unavailable for true emergencies and is the highest cost method of transportation within our health care system.		
		Adopt a recommended approach(es) and develop related performance objectives by June 30, 1999.

Performance Objectives	Outcomes Achieved	Planned Actions for Next 12 Months[1]
10 Strategic Planning for Local Communities Rural communities recognize the value of strategic planning for their communities, but often do not have the resources or expertise locally to conduct it.		
		Adopt a recommended approach(es) and develop related performance objectives by June 30, 1999.
11 Communication The lack of effective cross-department communication and coordination on rural health activities among federal, State and local departments adversely impacts rural communities.		
1. Develop a "Frequently Asked Questions" webpage, to improve rural providers' access to commonly requested information.	1. "FAQ" page is operating with DHS information. It is immediately expandable as other departments add content.	1. FAQ Project completed; continue to update page with new information.
		2. Adopt a recommended approach(es) and develop related performance objectives by June 30, 1999.
12 Workforce Availability Rural health providers face difficulties in recruiting clinical providers and experienced, knowledgeable administrative staff. Even if providers are successful in recruiting such individuals, the providers then face the challenge of retaining them.		
		Adopt a recommended approach(es) and develop related performance objectives by June 30, 1999.

1998 RHPC PROJECT UPDATES

- **Audit Consolidation Project**

  The topic of standardization and consolidation has been ranked as the highest priority by the Policy Council. The Policy Council directed the Coordinating Committee to focus on the auditing subsection of standardization and consolidation topic and to produce a deliverable product in 1998. The Coordinating Committee formed a task group that reviewed a draft report compiled by DHS Audits and Investigations staff. The Policy Council asked for the findings to be readied for public discussion, and report findings were presented at the June 12, 1998, RHPC Public Meeting. This report is accessible from the RHPC homepage (www.ruralhealth.ca.gov).

  Major Findings:
  - There is an appearance or perception on the part of the provider community that there are "too many auditors" visiting the same facilities.
  - There are also a great number of different funding streams available to the same provider. These funding streams have often been created at the request of the community. Separate funding streams have different rules, and this factor makes consolidation of the programs difficult.
  - The concept of creating a single examination/review team to perform all the necessary and required work, while sounding reasonable, does not appear to be practical, expedient or eminent in the near future, due to many federal and state regulations.
  - The task group found that each department represented in the review has made and continues to make strong efforts to avoid duplication in the provider audits. Many of these efforts appear to be going on as a part of the daily work.

- **Rural Resource Directory/ "Frequently Asked Questions" Page on the Website**

  The Coordinating Committee has developed a Rural Resource Directory to help users locate State agency resources more quickly. In developing a directory, several desired characteristics were identified:
  - The directory should be designed for an Internet environment, with hard copy for those still without Internet access.
  - The information needs to be more than a telephone book, and should focus on "Frequently Asked Questions" and other useful information developed to fit each RHPC department's situation.
  - The information should be kept up to date, and would ideally not require frequent revision. If it does, the extra resources needed to keep it current should be identified.

  After testing suggested formats, the IRHCC recommended to the RHPC that it develop one overall "Frequently Asked Questions" page at the RHPC website. This FAQ webpage has been initiated with input from DHS' Audits and Investigation and the Primary Care and Planning Divisions, and is expandable as other RHPC departments develop content. The webpage is currently operating, and is accessible from the RHPC homepage (www.ruralhealth.ca.gov).

SUMMARY OF RHPC GRANT ACTIVITY

The following statistics indicate activity in the RHPC competitive grants program:

	FY 1996-97	FY 1997-98	FY 1998-99
Small Grants			
RFA packets mailed	--	300+	213
Applications received	57	120	In process
Grants awarded	40	55	In process
Total awarded	$1,000,000	$1,370,471	$1,000,000
Range of awards	$25,000	$22,990 – 25,000	max=$25,000
Collaborative Grants			
RFAs packets mailed	--	N/A	N/A
Applications received	34	--	--
Grants awarded	8	--	--
Total awarded	$1,485,601	--	--
Range of awards	$117,667 - 200,000	--	--
Hospital Grants			
Number of eligibles	75	75	67
Applications received	30	46	42
Grants awarded	30	46	In process
Total awarded	$2,500,000	$528,990	$1,000,000
Range of awards	$1,962 - 325,778	$3,000 – 25,000	$6,000 - 25,000

- This grant program is authorized in Health and Safety Code Section 1179.3.

- Total funds appropriated in each fiscal year are as follows: FY 1996-97 equaled $5,000,000; FY 1997-98 equaled $1,903,000, and FY 1998-99 equaled $2,000,000. The fund source is the Cigarette and Tobacco Surtax Fund created by Proposition 99.

  The purpose of these funds is to deliver health and medical services in rural areas of the State. The funds are used exclusively for medical and hospital treatment for patients who cannot afford to pay for services and for whom payments will not be made though private or public programs. Several providers have testified to the immediate benefits of the grants program; for example, a clinic can open on Saturdays in a rural area where residents are migrant and seasonal farmworkers who cannot seek health care during the week.

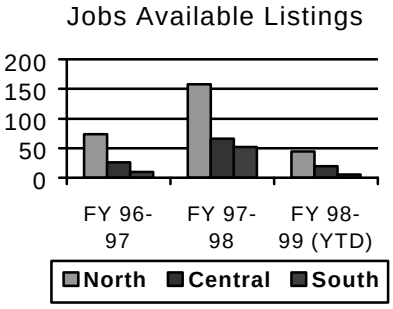
- In the current year, Rural Health Services Small Grants may apply for up to $25,000. Applicants are to address problems of access to quality health care in rural areas and how to compensate public and private health care providers for costs associated with the direct delivery of patient care. The Rural Hospital Services Grants will range from $6,000 to $25,000, based on reported levels of uncompensated care among the eligible rural hospitals.

RHPC OFFICE OBJECTIVES

Described below are the five core lines of business for the RHPC Office. Within each area are the systems or projects in current operation. Each system has been reviewed and objectives determined for the coming year

1. Workforce Development

- **Jobs Available Program**
  The RHPC assists the rural providers by aiding in their recruitment process for health care professionals. The California Jobs Available Program advertises available clinical, ancillary, and administrative positions in rural hospitals, clinics, and long-term care facilities. As a member of the National 3-R Net Program at the University of Wisconsin, these positions are listed on the World Wide Web. The rural providers can submit the criteria through the Internet, where it is received in the RHPC Office and posted on the Jobs Available website (www.ruralhealth.ca.gov/ruraljob).



  Objective: To list a total of 750 jobs by the end of FY 1998-99.

2. Funding

- **Rural Health Services Grants Program**
  The Rural Health Services Grants Program benefits providers directly by providing grants to hospitals, clinics, community-based programs, and counties. These grants are competitive and directed for one-time projects to expand services to the uninsured in the areas of alcohol and drugs, emergency medical services, mental health, and health services. See page 30 for details.

  Objective: To continue providing policy analysis and administrative support to DHS and OSHPD processes for awarding and administering these grants.

- **Links to Other Funders on RHPC Website**
  The RHPC website maintains categorized funding opportunities and sources pages. The "Funding Opportunities" page lists current grant programs, categorized by federal, state, local and regional, and private sources.

  Objectives: To increase funding source listings on RHPC website or links to other funders during FY 1998-99.
  To highlight at least eight new funding sources per year in the "Rural Health Newscast."

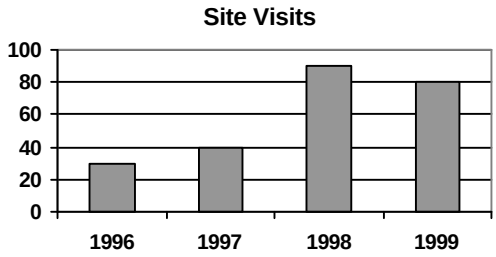
3. Assistance

- **Service Requests**
  Constituent requests for information, reports, or referrals to other departments within the Health and Welfare Agency are tracked through completion.

  Objective: To enter and track 100% of service requests and resolve 95% of the requests to the satisfaction of the constituent.

- **Site Visits**
  The Rural Health Program Liaison visits provider sites as requested by rural health providers, hospitals and county health agencies.

  Objective: To complete 80 site visits during calendar year 1999.



- **Technical Assistance**
  The RHPC Office assists providers when special needs are identified that can be met through expertise from within the rural health network. The RHPC Office arranges these matches of constituent needs with network resources.

  Objective: To meet 100% of requests for assistance.

4. Coordination

- **Public Meetings & Coordination of Joint Meetings**
  The Rural Health Policy Council holds four public meetings per year to listen and respond first-hand to constituents' concerns, issues and successes. The Policy Council coordinates its public meetings with other statewide and/or regional meetings in order to improve the exchange of information and ideas and for the convenience of constituents. For 1998, the Policy Council held two of its four public meetings in conjunction with other organizations, including the Rural Healthcare Center, California State Association of Counties, and the California Trade and Commerce Agency. The RHPC Office supports the meeting and agenda management for these public meetings, as well as for the internal meetings of the Policy Council and the IRHCC.

  Objectives: To increase attendance at the 1999 public meetings over the 1998 levels.
  To convene all RHPC public meetings in 1999 in conjunction with the annual meeting of another organization.

- **Annual Workplan and Annual Report to the Legislature**
  Pursuant to legislation, the RHPC Office is responsible for preparing the Annual Workplan for the Policy Council to adopt. It will also prepare the required Annual Report to the Legislature on performance objectives. In conjunction with the Workplan, the RHPC Office will continue to assist the IRHCC in its Workplan projects undertaken at the request of the Policy Council.

Objectives: To support the Policy Council's ongoing Workplan projects and meet legislative reporting requirements.

- **Issues Tracking**
  The RHPC Office tracks rural health issues brought to the attention of the Policy Council by public meeting, letter, fax, phone call, meeting or e-mail. The RHPC Office determines whether the issue should be referred to a single department or is an overarching issue that should be recommended for inclusion in the workplan. The RHPC Office follows up to determine that responses to the constituents have been sent from the appropriate department to which the issue was referred.

  Objective: To close out all issues received during FY 1997-98 by December 1998, and so forth for each following fiscal year.

- **Attendance at Rural Organizations Meetings**
  The RHPC Office participates in the meetings of various organizations in order to exchange information and work on issues of mutual concern. These include the following on a monthly, quarterly and/or annual basis:
    - County Health Executive Association of California and its Small Counties Committee
    - California State Rural Health Association
    - Northern California Rural Roundtable
    - County Medical Services Program Planning Committee and Board
    - California Primary Care Association
    - California Rural Development Council
    - County Alcohol and Drug Programs Association of California
    - California Healthcare Association Board/Rural Healthcare Center, and
    - California State Association of Counties.

  Objective: To continue attendance at association and board meetings in order to increase communication and ability to respond to issues.

5. Information Services

- **Newsletter**
  The "Rural Health Newscast" is sent to over 1,500 constituents approximately eight times per year. This newsletter contains information on upcoming events, funding opportunities, and technical assistance. State and federal regulation and statute changes of critical importance to rural health care providers are included.

  Objectives: To send eight issues during FY 1998-99.

- **RHPC Database**
  The RHPC database contains service requests, issues, and constituents.

  Objectives: To redesign the database structure to include Medical Service Study Area data, OSHPD clinic and hospital data, and DHS licensing data. These

additional links will provide custom reports to providers that will assist them in decision-making and in meeting government reporting requirements. To update database records and add capability to send the newletter and other messages by group e-mail.

- **RHPC Website**
  The RHPC website maintains current information on the RHPC, a funding clearinghouse for grant information, links to State grant applications for rural health, upcoming meeting dates and links to a statewide calendar of events and the "Jobs Available" website. Past RHPC reports and issues of the "Newscast" are retrievable. Links to important national rural health-related websites are maintained.

  Objective: To continue posting of new information throughout the year, and to test all links monthly to ensure that they are still current.

- **Mapping**
  The RHPC Office has acquired desktop mapping software.

  Objective: To create maps for distribution to constituents to assist them in decision-making, including (1) customized demographic maps of census data; (2) maps that plot health care delivery sites, e.g., clinics, hospitals, and county facilities, and (3) other data maps, upon request.

- **Toll-free Number**
  The RHPC Office maintains a toll-free number (California callers only) by which constituents gain access to the state agencies and acquire information, request assistance, obtain reports and maps, and are referred to other sources.

  Objective: To respond to all calls immediately during working hours, or as soon as possible on the next working day.

APPENDICES

1. **Authorizing Statutes**

2. **Member Departments: Interdepartmental Rural Health Coordinating Committee**

3. **List of Acronyms**

Appendix 1

Authorizing Statutes

Health and Safety Code Sections:

1179. The Legislature finds and declares all of the following:
(a) Outside of California's four major metropolitan areas, the majority of the state is rural. In general, the rural population is older, sicker, poorer, and more likely to be unemployed, uninsured, or underinsured. The lack of primary care, specialty providers and transportation continue to be significant barriers to access to health services in rural areas.
(b) There is no coordinated or comprehensive plan of action for rural health care in California to ensure the health of California's rural residents. Most of the interventions that have taken place on behalf of rural communities have been limited in scope and purpose and were not conceived or implemented with any comprehensive or systematic approach in mind. Because health planning tends to focus on approaches for population centers, the unique needs of rural communities may not be addressed. A comprehensive plan and approach is necessary to obtain federal support and relief, as well as to realistically institute state and industry interventions.
(c) Rural communities lack the resources to make the transition from present practices to managed care, and to make other changes that may be necessary as the result of health care reform efforts. With numerous health care reform proposals being debated and with the extensive changes in the current health care delivery system, a comprehensive and coordinated analysis must take place regarding the impact of these proposals on rural areas.
(d) Rural areas lack the technical expertise and resources to improve and coordinate their local data collection activities, which are necessary for well-targeted health planning, program development, and resource development. Data must be available to local communities to enable them to plan effectively.
(e) The Legislature recognizes the need to take a comprehensive approach to strengthen and coordinate rural health programs and health care delivery systems in order to:
(1) Facilitate access to high quality health care for California's rural communities.
(2) Promote coordinated planning and policy development among state departments and between the State and local public and private providers.

1179.1. (a) The Secretary of the Health and Welfare Agency shall establish an Office of Rural Health, or an alternative organizational structure, in one of the departments of the Health and Welfare Agency to promote a strong working relationship between state government and local and federal agencies, universities, private and public interest groups, rural consumers, health care providers, foundations, and other offices of rural health, as well as to develop health initiatives and maximize the use of existing resources without duplicating existing effort. The office or alternative organizational structure shall serve as a key information and referral source to promote coordinated planning for the delivery of health services in rural California.
(b) To the extent funds are appropriated by the Legislature, these efforts may include:
(1) Educating the public and recommending appropriate public policies regarding the viability of rural health care in California.
(2) Monitoring and working with state and federal agencies to assess the impact of proposed rules and regulations on rural areas.
(3) Promoting community involvement and community support in maintaining, rebuilding, and diversifying local health services in rural areas.
(4) Encouraging and evaluating the use of advanced communications technology to provide access to health promotion and disease prevention information, specialty expertise, clinical consultation, and continuing education for health professionals.

(5) Encouraging the development of regional health care and public health networks and collaborative efforts, including, but not limited to, emergency transportation networks.
(6) Working with state and local agencies, universities, and private and public interest groups to promote research on rural health issues.
(7) Soliciting the assistance of other offices or programs of rural health in California to carry out the duties of this part.
(8) Disseminating information and providing technical assistance to communities, health care providers, and consumers of health care services.
(9) Promoting strategies to improve health care professional recruitment and retention in rural areas.
(10) Encouraging innovative responses by public and private entities to address rural health issues.

1179.2. (a) The Health and Welfare Agency shall establish an interdepartmental Task Force on Rural Health to coordinate rural health policy development and program operations and to develop a strategic plan for rural health.
(b) At a minimum, the following state departmental directors, or their representatives, shall participate on this task force:
(1) The Director of Health Services.
(2) The Director of Statewide Health Planning and Development.
(3) The Director of Alcohol and Drug Programs.
(4) The Director of the Emergency Medical Services Authority.
(5) The Director of Mental Health.
(6) The Executive Director of the Managed Risk Medical Insurance Board.
(c) The task force shall review and direct the activities of the Office of Rural Health or the alternative organizational structure, as determined by the Secretary of the Health and Welfare Agency.
(d) The task force shall establish appropriate mechanisms, such as ad hoc or standing advisory committees or the holding of public hearings in rural communities for the purpose of soliciting and receiving input from these communities, including input from rural hospitals, rural clinics, health care service plans, local governments, academia, and consumers.
(e) By May 1, 1996, the Secretary of the Health and Welfare Agency shall report to the Chair of the Joint Legislative Budget Committee and the Chairs of the Senate and Assembly Health Committees, and at that time submit the strategic plan developed by the task force. This strategic plan may include but shall not be limited to the following elements:
(1) The status of establishing an Office of Rural Health or alternative organizational structure.
(2) The roles and responsibilities of that office or alternative organizational structure.
(3) The mechanism for ongoing input to the office or alternative organizational structure by members of the public, rural health care providers, rural hospitals, health care service plans, and local governments.
(4) The identification of all departments and agencies with significant program or funding responsibility for rural health care.
(5) A detailed plan to consolidate and coordinate the activities of the programs identified pursuant to paragraph (4) to better meet the health care needs of rural residents.

1179.3. (a) (1) The Rural Health Policy Council shall develop and administer a competitive grants program for projects located in rural areas of California.
(2) The Rural Health Policy Council shall define "rural area" for the purposes of this section after receiving public input and upon recommendation of the Interdepartmental Rural Health Coordinating Committee and the Rural Health Programs Liaison.
(3) The purpose of the grants program shall be to fund innovative, collaborative, cost-effective, and efficient projects that pertain to the delivery of health and medical services in rural areas of the state.
(4) The Rural Health Policy Council shall develop and establish uses for the funds to fund special projects that alleviate problems of access to quality health care in rural areas and to compensate public

and private health care providers associated with direct delivery of patient care. The funds shall be used for medical and hospital care and treatment of patients who cannot afford to pay for services and for whom payment will not be made through private or public programs.

(5) The Office of Statewide Health Planning and Development shall administer the funds appropriated by the Budget Act of 1998 for purposes of this section. Entities eligible for these funds shall include rural health providers served by the programs operated by the departments represented on the Rural Health Policy Council, which include the State Department of Alcohol and Drug Programs, the Emergency Medical Services Authority, the State Department of Health Services, the State Department of Mental Health, the Office of Statewide Health Planning and Development, and the Managed Risk Medical Insurance Board. The grant funds shall be used to expand existing services or establish new services and shall not be used to supplant existing levels of service.

(b) The Rural Health Policy Council shall establish the criteria and standards for eligibility to be used in requests for proposals or requests for application, the application review process, determining the maximum amount and number of grants to be awarded, preference and priority of projects, compliance monitoring, and the measurement of outcomes achieved after receiving comment from the public at a meeting held pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(c) The Office of Statewide Health Planning and Development shall periodically report to the Rural Health Policy Council on the status of the funded projects. This information shall also be available at the public meetings.

(d) This section shall become inoperative on July 1, 1999, and, as of January 1, 2000, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2000, deletes or extends the dates on which it becomes inoperative and is repealed.

1179.5. (a) The Rural Health Policy Office within the Office of Statewide Health Planning and Development serving as staff to the Rural Health Policy Council shall develop an annual workplan which is adopted by the council. The workplan shall describe how the council shall meet specific, measurable performance objectives. The workplan shall be designed to further the goals of the Rural Health Policy Council to improve access to, and the quality of, health care in rural areas.

(b) The workplan required under subdivision (a) shall include information on how the council intends to address, at a minimum, all of the following topics:

(1) Increased standardization and consolidation of financial and statistical reporting, billing, audits, contracts, and budgets.

(2) Network delivery and integrated delivery systems.

(3) Streamlining the regulatory process.

(4) Assessing the impact of managed care in rural communities.

(5) Reviewing and proposing changes necessary to improve current funding issues.

(6) Increasing the use of technology.

(7) Supporting innovative efforts to improve patient transportation.

(8) Providing strategic planning for local communities.

(9) Improving communication between the state and rural providers.

(10) Increasing workforce availability in rural areas.

(c) The Rural Health Policy Council shall provide an annual report to the chairs of the fiscal and policy committees of the Legislature on the outcomes achieved by the office during the preceding 12 months and what changes it will incorporate into the workplan for the following year. The first report pursuant to this section shall be provided to the Legislature by February 1, 1999.

Appendix 2

Member Departments:
Interdepartmental Rural Health Coordinating Committee

State agencies currently represented include:

- Department of Health Services:
  - Audits and Investigations
  - Health Information and Strategic Planning
  - Licensing and Certification
  - Medi-Cal Policy
  - Office of County Health Services
  - Primary Care and Family Health

- Office of Statewide Health Planning and Development:
  - California Health Information for Policy Project
  - Cal-Mortgage Loan Insurance Division
  - Facilities Development Division
  - Primary Care Resources and Community Development Division

- Department of Alcohol and Drug Programs

- Emergency Medical Services Authority

- Department of Mental Health:
  - Technical Assistance and Training

- Managed Risk Medical Insurance Board

- Department of Community Services and Development:
  - Farm Worker and Community Services Programs

Representation is determined by the department directors of the Rural Health Policy Council, and may include representatives of State departments, in addition to the RHPC departments, that wish to participate.

Appendix 3

List of Acronyms

3R-Net	(National) Rural Recruitment and Retention Network
AB	Assembly Bill
ADP	Department of Alcohol and Drug Programs
ALS/BLS	Advanced Life Support/Basic Life Support
CA	California
CMSP	County Medical Services Program
DHS	Department of Health Services
DMH	Department of Mental Health
DRIS	Developing Rural Integrated Systems
EMSA	Emergency Medical Services Authority
ENT	Ear-Nose-Throat
FQHC	Federally Qualified Health Center
FSR	Feasibility study report
FY	Fiscal Year
HCTF	(Trinity County) Health Care Task Force
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HWA	Health and Welfare Agency
IRHCC	Interdepartmental Rural Health Coordinating Committee
ISDN	Integrated Services Digital Network
MRMIB	Managed Risk Medical Insurance Board
MSSA	Medical Service Study Area
OSHPD	Office of Statewide Health Planning and Development
PL	Public Law
RFA	Request for Application
RHPC	Rural Health Policy Council
T1	Transmission medium (Digital Signal Level One)
TH/TM	Telehealth/Telemedicine
YTD	Year-to-Date

READER'S FEEDBACK AND RESPONSE

We hope to improve and expand the usefulness of our report to the rural health community. Would you take a few minutes and provide us with your comments and suggestions?

Reader Comments:

I would like to see future editions include information on:

What I like about this report is:

Ways that you could improve this report are:

Other comments:

Optional: Name:
Address:
Phone Number:

Please tear out and send to:

Rural Health Policy Council Office
1600 Ninth Street, Room 439C
Sacramento, CA 95814

Or FAX to: (916) 654-2871